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ABSTRACT

This paper examines the use of the peer review system in evaluating out-patient clinical services for a third-party payer seeking justification for payment of services. Peer review is defined as a process by which one professional, in an official capacity, makes a judgment about a co-professional in a matter involving professional functioning. The contracts between psychologists and psychiatrists and CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), a health benefit program for retired military personnel and military dependents, are discussed. The review process is followed from the third-party payer request for an evaluation to disposition of the case. Similarities between the review systems implemented for CHAMPUS and the private insurance companies are reviewed, and the selection of reviewers is discussed. Criticisms of the project are noted, particularly regulations directed against the third-party payer, the mechanics of implementation of the system, accountability issues, and specific review criteria. Responses to these criticisms are cited, including criteria modifications, additional research, and a review of recommendations from the CHAMPUS National Advisory Panel. (JAC)

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PEER REVIEW: The CHAMPUS Program

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Peer Review: The CHAMPUS Program

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The pursuit of accountability must take into account the functions of both utilization review and quality assurance. Utilization review is primarily concerned with financial and legal matters and has cost containment as its primary objective. It is best handled through administrative activities in the service of the efficient use of resources, often involving the administrative management of waste, fraud and abuse. This responsibility often falls under the purview of the institution responsible for the management of funds, such as an insurance company. Quality assurance, on the other hand, is primarily concerned with professional and ethical issues and has, as its goal, an appraisal of the quality of professional services offered to the public. One current strategy which is aimed primarily at the effective discharge of quality assurance is peer review.

Peer review may be defined as a process by which one professional, in an official capacity, makes a judgment about a co-professional in a matter involving professional functioning. In many ways, it represents an issue for the 1980's and provides the focus of attempts to assure professional accountability. A moment's reflection, however, makes it obvious that psychology

has a long history of involvement with peer review. Articles are accepted for publication in journals on the basis of reviews by peers. Research grants are awarded on the basis of an extensive peer review system. Decisions as to tenure and promotion in an academic setting are made by colleagues of the candidate. The award of the Diplomate is made on the basis of a judgment by a committee of peers. Policies and activities in the areas of licensing, ethics and continuing education are all under the jurisdiction of peers. Clearly, the idea that peers can make important judgments about each other is well accepted.

The specific focus of the peer review system addressed in this paper concerns the evaluation of out-patient clinical services. This system was initially stimulated and financed by a third party payer which was seeking some justification for the continuance of payment for services.

It is important to understand the system of payment regulation that was in existence prior to the development of the peer review program. It was an actuarial system that was implemented by non-psychologists. Decisions were rendered either by subdoctoral members of another profession, by physicians, often without psychiatric training, or by a clerk. These options continue to be utilized by some third party payers who do not subscribe to the peer review program. The primary decisions

about payment were based on prior experience with the diagnostic entity being treated. The only two alternatives to peer review were the establishment of a policy benefit ceiling and the elimination of the mental health benefit. The willingness of psychology and psychiatry to assume the responsibility of self regulation allowed an increase in the extent to which the needs of the patient governed the limits of the benefit, but it required the assumption that the profession would be willing to take the responsibility of indicating where treatment might not be necessary or appropriate.

History of the Project

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a health benefit program which serves approximately eight million beneficiaries, primarily retired members of the armed forces and the dependents of active duty members. It is the largest health benefits program in the world. It is also a program noteworthy because of its enlightened attitude toward mental health service. Psychologists have been recognized as independent providers of professional services since the inception of the CHAMPUS mental health benefit in 1966. Further, limits to benefits, other than those specified in contractual regulations, are dictated exclusively by patient needs, rather than by any fixed dollar or session amount. Since CHAMPUS is an

agency of the Department of Defense, the budget for this program is authorized annually by the Congress. Concerns about the excessive costs of the program, accompanied by some specific, documented history of abuse, led to a threat of curtailment of the mental health benefit. As an alternative to the benefit reduction, and in light of prior positive experiences with peer review systems, CHAMPUS was willing to enter into a contract with the American Psychological Association (APA) in 1977 providing for the development of a peer review system. At the same time, a parallel contract was signed with the American Psychiatric Association, and essentially the same process applies to services delivered by members of both professions.

The system that was developed under the APA/CHAMPUS contract was not implemented until 1980, but is currently fully operational. Prior to implementation, in the summer of 1979, the Aetna Life and Casualty Insurance Company became the first third party payer to subscribe to the APA peer review system. A number of other third party payers, such as Prudential and Mutual of Omaha, also participate in this program, and it is possible that as many as ten separate insurance companies will sign contracts with APA in the near future. If the system proves to be successful, it is likely that a number of other insurance companies will sign contracts, and any National Health Insurance program that may develop in the distant future might well utilize this approach to

accountability. The present alternative to the APA peer review system seems to be the adoption of relatively stringent policy limits, such as a $500 ceiling on benefits, which eliminates the need for strict accountability, but also is far less responsive to the mental health needs of beneficiaries.

Within this peer review system, the process of review follows a general structural path within all companies. At some predetermined point the third party payer requests that the provider complete a report form and submit relevant information to the company. This report is reviewed by a person in the utilization review branch, who then makes a determination as to disposition. This determination usually is to pay the claim, but at some point it will be to submit the case for peer review. In that event, the case has all identifying information removed, and is sent to three paid reviewers, working independently, each of whom submit an advisory opinion to the company. The company then makes a decision and communicates it, with the concerned parties retaining a right of appeal if the decision should be unfavorable. This entire procedure is monitored by APA, which can intervene if the system goes awry.

There are a great number of similarities among the review systems implemented for CHAMPUS and the private insurance companies, and there also are some highly significant differences.

The primary similarity is in the commitment to the concept of quality assurance, with reviews provided by peers on the basis of professional judgment. In all systems, there is local review performed under centralized coordination. The same network of reviewers is used, and the case is given three independent reviews by psychologists who ordinarily are located within the same state as the provider being reviewed. The system is coordinated by APA, and the reviews are advisory to the third party payer.

The network of reviewers chosen by APA to perform this function now numbers over 400 psychologists. Shortly after the contract was signed, nominations were solicited from the President of each State Psychological Association and the Chair of the Professional Standards Review Committee (PSRC) in each state. Applications were reviewed, and recommendations made, by the National Advisory Panel appointed by APA to discharge the contractual responsibilities of the project. Aside from demographic considerations, the minimum criteria used for selection were: a) at least 5 years of post-doctoral experience; b) at least 10 hours of weekly direct service involvement; c) full independent licensure/certification status in the jurisdiction of current practice; and d) no more than half time federal employment or 25% CHAMPUS practice. The roster of reviewers was established to function on a rotational basis, so that there will be continuing opportunities for psychologists who meet the criteria to become

reviewers, receive training, and become actively involved in the peer review system.

One major departure of the APA system from prior approaches to review is that psychiatric diagnosis plays no part in the review decision. A diagnosis is included on the claim form because of insurance requirements, but this diagnosis is not related to the review decision, which is based on the substance of the treatment. Although there is a reliance by all peer review systems on data which are supplied by the providers, this is particularly true in this system, since clinical considerations are paramount for review decisions. The key elements in the forms used to elicit the data include a description of the presenting problem and current status of the patient, a statement of the progress that has been made since the beginning of treatment, a statement of the goals of treatment and an account of the methods of intervention which will be used in order to meet those goals. The data must be sufficiently well developed to allow for review decisions, but need not go into excessive historical and dynamic details.

There is a great deal of attention paid to the confidentiality of these communications. No material leaves the office of the third party payer before names of both the patient and the provider are deleted. Within the office of the third party payer, the material is kept within the utilization review branch of the

company in files separate from claim forms. The files are locked and access to them is limited to people who are directly involved in making review decisions. Material is destroyed after sufficient time has passed to allow any right of appeal to be exhausted. APA would not enter into a contract without adequate assurance that confidentiality would be maintained. Furthermore, any indication that contractual provisions were being violated would lead to internal efforts to restore confidentiality, with the likelihood that the contract would not be renewed if this could not be accomplished.

There are also a number of critical differences between CHAMPUS and the private insurance companies, and a number of differences among the various insurance companies. The forms used to elicit data vary somewhat, although efforts are being made to produce a single format to be used by all companies. The report points for CHAMPUS review are mandated by a CHAMPUS regulation and initially were set at the eighth, twenty-fourth fortieth and sixtieth sessions. Experience with these report points has led to a proposed change in the regulation, and it is likely that future review will be less frequent and initiated later in treatment. Reporting points established by the private insurance companies vary according to internal policies, but usually reports are not solicited before the thirtieth session.

Within CHAMPUS, the basis for submitting a case for peer review, after the report is received, is an elaborate set of criteria devised by the National Advisory Panel. These criteria are stated in a public document which has appeared in the literature, and which is also available through APA. The private insurance companies use a variety of criteria, some of which are explicitly stated, while others of which appear to reflect the predilection of the director of the utilization review branch within the company. In all cases, final decisions are rendered by the company rather than by the peer reviewers, whose opinions are only advisory. The companies also differ as to whether these advisory opinions will be made available to the provider, with some CHAMPUS claims processors and many of the insurance companies routinely sending the provider verbatim copies of the reviewer comments.

The data concerning the review process varies widely depending upon the company. CHAMPUS, because it requires reviews at a relatively early point in treatment, will ask for information from a higher percentage of providers than will the private insurance companies. When CHAMPUS converts to a later initial report point, it is likely that over half the cases in treatment will never be subject to the provision of report forms, and companies with later report points may allow well over 90% of

cases to be reimbursed without any demands for more than rudimentary information. The great majority of cases for which information is provided lead to decisions within the company office, so that only approximately 2% of these cases are actually sent out for peer review. Of cases which are sent for review, past benefits are paid at a rate well in excess of 90%, and future benefits are approved as requested in approximately half the cases. While specific numbers are not being given, since they will vary widely from company to company, the general principle is that most cases will not require any report, most reports will not lead to peer review, and most peer reviews will not lead to reductions in benefits. The actual proportion of claims submitted which eventually have benefits reduced is less than one in a thousand, and there are a small number of cases in which benefits may be increased. Nevertheless, in some specific individual cases, negative decisions are made concerning benefits. More importantly, the very presence of the system may have what one medical director refers to as a "sentinel effect," whereby providers monitor their own practices more carefully because of the existence of peer review.

Criticisms of the Project

The implementation of the peer review project has drawn a range of criticisms from within the profession. In some cases, these criticisms were stimulated by regulations of the third party

payer which were in existence prior to the project. For example, many companies do not reimburse specific approaches to treatment, such as biofeedback, and would not do so whether or not peer review was in existence. In fact, the National Advisory Panel has occasionally been able to play the role of an ombudsman for the profession, and has succeeded in suggesting a number of modifications in regulations where such actions are consistent with our best information about professional practice. For example, allowable time for group therapy under CHAMPUS has been increased from 60 minutes to two hours after Panel initiatives.

In other circumstances, criticisms were directed against the mechanics of implementation of the system. While the system was put into operation in most areas of the country with little difficulty, some areas experienced a remarkable number of internal problems including excessive delay in processing claims, faulty communications, distorted communications, and inconsistent enforcement of the regulation. These problems are not inherent in a peer review system but certainly represent the growing pains of the system. They also created undue hardships for a large number of providers. Immediate attention was directed to these problems, and it appears as though most of them have been corrected at the present time. It is not unlikely that scattered operational problems will return and, again, the National Advisory Panel is responsive to having such problems called to its attention and

using its office to correct these problems wherever possible.

Finally, a number of criticisms were directed at aspects of the system which are directly and inherently a part of the system itself. Most psychologists did not criticize the principle of peer review directly, although there were occasional statements that any attempt to interfere with the independence of the practitioner was unwarranted and inappropriate. Providers who do not wish to participate in any system of accountability are best advised to seek patients who do not rely on insurance reimbursement, since it is unlikely that any insurance company is going to be willing to provide payment without any information request. On the other hand, there are a number of providers who accept the principle of accountability, but object to some of the specifics of the system that was developed. Criticisms include challenges to a number of specific review criteria, a question as to whether decisions should be made on the basis of "reasonable and customary" rather than "necessary and appropriate," and some general questions about the validity of any document-based review system. In response to these criticisms, a number of specific criteria have already been modified and an extensive nationwide survey has been conducted which will lead to the reconsideration of many other criteria. Research, which is to be described, has influenced a number of the operational aspects of the system, and there is an ongoing attempt to alter the system in accordance with

empirical data on clinical practice patterns and psychological peer review.

Within APA, the actions of the National Advisory Panel are now firmly embedded within the general system of governance, so that all decisions that involve policy are reviewed by the Committee on Professional Standards and ultimately by its parent body, the Board of Professional Affairs. Efforts are currently under way to integrate the APA system with the state PSRC's, a move toward decentralization suggested by many critics of the program. The criticisms of the system had a number of very important effects and, on balance, led to a general improvement in the quality of APA's approach to peer review.